Erratum

P586 Osteoarticular Involvement of Brucellosis in Turkey

Y. Taşova, N. Saltoğlu, H.S.Z. Aksu. *Department of Infectious Diseases, Medical School, Çukurova University, Adana, Turkey*

Objectives: To detect the rate and types of osteoarticular involvement of Brucellosis at a university hospital in Turkey

Methods: The clinical laboratory information and imaging studies from patients (examined between 1990–1996) with the diagnosis of osteoarticular involvement in Brucellosis were reviewed. The diagnosis was established on the basis of Brucella spp. from blood cultures (n: 8) or characteristic clinical findings of brucellosis and standard tube agglutination titer of 1/160 or more (n: 52) and one or more imaging examinations with finding consistent with osteoarticular involvement.

Results: Among the 170 patients diagnosis of brucellosis, 60 (35.3%) had osteoarticular involvement median age was 36–35 were female (58.3%) and 25 were male (41.7%). Body temperature was elevated to 37.5°C or above in 54 (90%) patients. The other most frequent symptoms were malaise, night sweating and arthralgias. The most frequent sings were hepatomegaly and splenomegaly. The possible source of infection wasn't identified 24 (40%) cases. The types and rates of osteoarticular involvement; sacroilitis (70%, 51% of them were bilateral), peripheralarthritis (15%, 77.7% of them were monoarthritis), spondilitis (11.6%, one case of them was cervical and the other cases of them were lomber regions), bursitis (5%) Erythrocyte sedimentation rates was > 40 mm/h. in 24 (40%) cases. The median age of the patients with spondylitis was 52.3 and in the other osteoarticular locations was 27.4. In the therapy cases without spondilitis were given doxycycline or ofloksasin of ciprofloxin plus rifampin or tetracycline plus streptomcin for six weeks. Cases with spondilitis taken co-trimoxazole plus doxycline plus rifampin over periods of 3–5 months. Relapse were only 3 pts. (5%).

Conclusions: In Turkey, Brucellosis should be taken into consideration in for osteoarticular manifestation and fever.

P1236 Nasal and Oral Fungal Colonization in Renal Transplant Patients

A. Džamć [1], S. Mitrović [1], V. Arsić [1], Z. Džamić [2], J. Hadži Djokić [2], I. Kranjčić-Zec [1]. [1] *Institute of Microbiology and Immunology,* [2] *Institute of Urology and Nephrology, University of Belgrade School of Medicine, Belgrade, Yugoslavia*

With the increasing success of organ transplantation, attention is now being turned to the long-term problem associated with chronic immunosuppressive therapy. The prevalence of nasal and oral fungal colonization was studied in 70 outpatients with functional renal grafts, 1 to 3 years post-transplant. The patients were on chronic immunosuppressive therapy with cyclosporine and corticosteroids. Fungi were isolated on Sabouraud agar plates at two occasions and identified by morphologic criteria, germ tube and chlamydospore formation and through assimilation test (API 20C AUX). Not included were yeasts recovered in low numbers. Moulds were demonstrated in nasal specimens in 15 patients: *Aspergillus* sp. (7/15), *Penicillium* sp. (3/15), *Culvularia* sp. (2/15), *Alternaria* sp. (1/15), *Cladosporium* sp. (1/15) and *Drechslera* sp. (1/15). Rich growth of yeasts was demonstrated from oral cultures of 18 patients. *Candida albicans* was the most prevalent isolate with 77.7% (14/18), followed by *C. tropicalis* (2/18), *C. krusei* (1/18) and *Cryptococcus neoformans* (1/18). The capsule and melanin production in vitro as most important virulence factors was demonstrated for the isolated strain of *C. neoformans*. *Aspergillus* sp. was isolated from oral cavity in one patient. Fungi are not the most common cause of infection in renal transplant recipients but they represent a serious complication because their therapy causes substantial toxicity and recovery is infrequent. We conclude that in patients more than one-year post-transplant with rich growth of fungi from mucosal sites, the surveillance oral cultures on regular controls should be performed in order to prevent systemic disease.

P1386 Human Granulocytic Ehrlichiosis (HGE): The First Human Case & Review of the Literature

A.A. Hamour [1], P. Brouqui [2], D.W. Denning [1]. [1] *Dept. of Infectious Diseases, North Manchester General Hospital, Manchester, M8 4RE, UK,* [2] *WHO Collaborative Centre for Rickettsial Reference and Research, 13385 Marseille Cedex 5, France*

Human granulocytic ehrlichiosis (HGE) is a rapidly emerging infection first recognised in the USA in 1994. We describe probably the first human case of HGE and review the relevant literature.

Case report: In April 1994 a 49-year old man was admitted with a 3-week history of fever, chills, sweating headache and anorexia, following a holiday in New Jersey, USA; where he had sustained a tick bite. He was pyrexial at 38.7°C and his conjuctivae were injected. Investigations showed lymphopenia (0.5×10^9/L), thrombocytopenia (9×10^9/L) and slightly deranged hepatic function. The peripheral blood film revealed intraneutrophil inclusion bodies. The patient responded promptly to a week's course of doxycycline. Subsequent serology showed a significant rise in the IgG and IgM titres to HGE which confirmed the diagnosis of HGE.

Conclusion: HGE should be considered in the differential diagnosis of fever and cytopenias in European travellers returning from the USA. The literature on HGE will be reviewed.

P1477 Peritoneal *Pneumocystis carinii* Infection in a Patient With AIDS: A Case Report and Review of the Literature

A. Uriel, A. Hamour, G. Wilson, B. Mandal. *Departments of Infectious Diseases and Histopathology, North Manchester General Hospital, Manchester, UK*

Extrapulmonary pneumocystosis is an uncommon manifestation of HIV infection which is being reported with increasing frequency in patients with AIDS particularly those who receive aerosolized pentamidine for PCP prophylaxis. We report what may be the first case of peritoneal pneumocystosis in Britain and review the literature on this subject. A 35-year-old homosexual man with advanced AIDS (CD4 27/cu mm) and previous PCP presented with abdominal pain, hepatosplenomegaly, and gross ascites. Cotton wool exudates were noted on fundoscopy. Due to septrin allergy and the development of pneumocystis carinii pneumonia (PCP) whilst on dapsone, he was receiving prophylactic aerosolised pentamidine (600 mg weekly). Investigations revealed pancytopenia, deranged coagulation and liver function tests and hypoalbuminaemia. Immunocytochemistry of ascitic fluid showed pneumocysts. Despite treatment with intravenous pentamidine, the infection proved fatal.

Peritoneal pneumocystosis should be considered in the differential diagnosis of hepatosplenomegaly and ascites in patients with AIDS who are on aerosolised pentamidine for PCP prophylaxis. A literature review of extrapulmonary pneumocystosis will be presented.